Case Management ADVISOR™
Covering Case Management Across The Entire Care Continuum

December 2012: Vol. 23, No. 12
Pages 133-144

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Financial disclosure:
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Maternity CM saves costs, prevents heartache

Cost of a preterm infant can last a lifetime

The old saying "An ounce of prevention is worth a pound of cure," couldn't be more appropriate than when it comes to preterm births.

A report by the Institute of Medicine — *Preterm Birth: Causes, Consequences, and Prevention* — estimates the cost of preterm births in the United States in 2005 totaled at least $26.2 billion. The March of Dimes estimates that the average cost for a preterm infant is $49,000 compared with an average of $4,500 for full-term infants.

A stay in the neonatal intensive care unit (NICU) costs an estimated $2,000 to $3,000 a day, depending on the needs of the infant, says **Angela Glyder**, RN, CCM, director of integrated case management for Select Health of South Carolina, a Charleston-based health plan. "The cost adds up quickly when you consider the extended inpatient stays we see with these NICU babies," she says.

The initial costs of preterm births are staggering, but they often continue long after infants are discharged from the neonatal intensive care unit (NICU), adds **Catherine M. Mullahy**, RN, BS, CRRN, CCM, president and founder of Mullahy and Associates, a case management consulting firm in Huntington, NY.

"So many preemie babies have long-term problems, and the cost of their care continues for over a lifetime," she says.

Preterm babies have a higher prevalence of cerebral palsy, mental retardation, vision problems, and hearing loss than their full term

EXECUTIVE SUMMARY

The costs of a preterm birth are staggering and often extend throughout the infant's life.
- Identify at-risk women as early as possible.
- Help them adopt healthy behaviors.
- Give particular attention to women on Medicaid.

counterparts and require medical care throughout their lifetime. In addition, premature and low birth weight infants often face development delays that impact them for many years. "They start from behind and it takes them a long time to catch up with their peers," Glyder says. *(For details on Select Health of South Carolina's Bright Start maternity case management program, see page 136).*

Cost is just one reason case managers should focus on preventing preterm deliveries, Mullahy says. Helping parents avoid the heartbreak and disappointment of coping when a child is in the NICU and needs extra care at home is another reason. "Case managers are involved in managing and preventing an array of medical conditions, but preterm deliveries is one of the most compelling," she adds.

Each year, almost 500,000 babies are born prior to 37 weeks gestation. That's one in every eight births, according to the Atlanta-based Centers for Disease Control and Prevention. Preterm delivery is the leading cause of infant death, the CDC adds.

"While preterm births comprise only 12% of all births nationwide, the staggering costs for early delivery are high," says **Heather Jarrett**, RN, BSN, senior vice president of government programs for Alere Health. Research shows that pregnancy case management programs can reduce pregnancy-related hospitalizations, she says. She recommends pregnancy management plans that include management for women during pregnancy and NICU case management for premature babies.

Early and consistent prenatal care identifies potential problems, and case management can engage pregnant women and educate them on how to stay healthy during pregnancy and identify warning signs that could indicate preterm labor, says **Sherry Rumbaugh**, RN, BSN, director of care coordination and quality for Passport Health Plan, with headquarters in Lexington, KY.

Passport's Mommy Steps Program, which focuses on three steps to a healthy pregnancy—regular doctor visits, healthy eating, and making good choices — consistently exceeds the state of Kentucky's goals for managing the care of at-risk pregnant women. *(For details on their program, see related article on page 138.)*

Case managers are in a position to educate women to have healthy pregnancies and avoid delivering premature babies, but first they have to identify them, Mullahy says. She advises case manager to look beyond the usual clues, such as a previous preterm birth or pregnancy-induced hypertension, to identify other women who may not be at risk.

For instance, women who conceive by in vitro fertilization, teenagers, and those over 35 should be in a high-risk program. Data from a wellness program can also indicate women at risk. For instance, cigarette smoking, poor nutri-

Case Management Advisor™ (ISSN# 1053-5500), is published monthly by AHC Media, a division of Thompson Media Group LLC, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Website: www.ahcmedia.com. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to Case Management Advisor™, P.O. Box 105109, Atlanta, GA 30348.

SUBSCRIBER INFORMATION

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcmedia.com). Hours of operation: 8:30 a.m.- 6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $399. Add $17.95 for shipping & handling. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. For approximately 15 CE nursing contact hours, $449. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. Back issues, when available, are $67 each. (GST registration number R128870672.)

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This activity has been approved for 15 nursing contact hours using a 60-minute contact hour. Provider approved by the California Board of Registered Nursing, Provider # 14749, for 15 Contact Hours.

This activity has been approved by the Commission for Case Manager Certification for 18 clock hours.

This activity is valid 24 months from the date of publication.

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EDITORIAL QUESTIONS

Questions or comments? Call Mary Booth Thomas at (770) 939-8738.

tion, excessive alcohol use, and substance abuse can also put women at risk, Mullahy says.

"Obesity is another factor that often gets overlooked, but women who are obese have a much higher instance of Type 2 diabetes and hypertension, both of which can put a pregnancy at risk," she says.

Pregnant women who are Medicaid recipients experience a higher percentage of adverse outcomes than those covered by commercial insurance, she says.

Case managers who work with pregnant Medicaid recipients should have a lower caseload than those working with a commercial population, Mullahy suggests.

"Patients in Medicaid plans tend to have a disproportionately large share of preterm births. In addition to other risk factors, these women may not have transportation or they may be in a rural area or inner city neighborhoods where physicians don't accept Medicaid. They need the best in medical care, and their lack of access to a provider could be a barrier," she says.

Roanna Williams, RN, CCM, supervisor of case management for BlueCross BlueShield of Tennessee, points out that Medicaid members have tremendous needs that include basic resources such as adequate food, shelter, utilities, and transportation to appointments. The health plan's CaringStart program provides face-to-face case management for women treated at a large obstetrical practice. *(For details, see related article below).*

"In some cases, Medicaid members may live in a rural area, or even an inner-city neighborhood where physicians don't accept Medicaid. They need the best in medical care during their pregnancy but often, they don't have access," Mullahy says. ■

Meetings help CMs, pregnant women bond

Incentives encourage keeping appointments

By meeting at-risk pregnant women face-to-face in their physician's office, a case manager from BlueCross BlueShield is able to successfully engage the Medicaid recipients in case management and work to meet their needs throughout the pregnancy.

"When the telephonic case managers call members, they're sometimes not open to participating in the program or think they have no need. It makes a big difference to have a person in the office who works with them face-to-face. Since we started the program in June 2012, nobody has turned us down," says **Roanna Williams**, RN, CCM, supervisor of case management for the Chattanooga-based health plan. BlueCross BlueShield of Tennessee covers its Medicaid members under the Volunteer State Health Plan.

The face-to-face interventions, part of the Caring Start in Your Neighborhood high-risk case management program, take place in an obstetrical practice office that treats a high volume of health plan members, many of whom are at high risk for complications of pregnancy and pre-term births.

In addition to the face-to-face program, the health plan's CaringStart program provides telephonic case management for high-risk women who see other providers during pregnancy. The health plan sends educational materials to all pregnant women.

The health plan uses its medical informatics tool to get weekly reports of women who are pregnant. The tool uses information from the state of Tennessee on newly eligible members who are pregnant, as well as claims data for prenatal vitamins, pregnancy tests, ultrasounds, or other procedures that indicate pregnancy. Referrals also come from physician offices.

The tool identifies pregnant women who have been treated for substance abuse, who had problems with a previous pregnancy, pre-term births, or other factors that indicate the women may be at risk for a preterm birth or other complications. Women who are under 17 and over 35 also are considered to be at risk.

The physician office selected for the

EXECUTIVE SUMMARY

BlueCross BlueShield of Tennessee has embedded a maternity case manager in the office of an obstetrical practice that sees a lot of the Chattanooga-based health plan's Medicaid members, many of whom are at risk.

- Case manager collaborates with a social worker and behavioral health professional.
- Program includes incentives for doctor visits, postpartum care.
- Other at-risk members receive telephonic case management.

CaringStart in Your Neighborhood program has provided office space for the health plan case manager and notifies her when at-risk members have an appointment. The case manager is in the office five days a week. A social worker shares her time between the obstetrical office and a nearby pediatric clinic. The case manager can call on behavioral health professionals as needed when members have issues such as substance abuse.

"Sometimes all three meet with the woman who has a lot of complicated needs," Williams says.

The health plan offers incentives to members in the face-to-face program. When they enroll, they receive a bag with baby supplies. They receive a gift card following every physician visit and a large gift card along with a baby bag filled with supplies when they come to their post-partum visit.

The case manager sees patients while they are waiting to see the doctor, and finds out how she can help. She educates them on healthy behaviors and what to expect during pregnancy. She does an initial assessment and reviews information from the physician office's records to find out about the home situation and the patient's social needs.

For instance, some women indicate that they are living with friends and don't have a place to live when the baby is born, or they don't have a crib or a car seat, and some don't have food in the house. Sometimes they tell the case manager about suffering domestic violence.

"It's amazing how needy this population is and how many resources they need," Williams says. The case manager is familiar with community resources that may help the member find housing assistance, help with utilities, food, and baby supplies and can call on the social worker for assistance. When the member has a lot of needs, both the social worker and the case manager help her access the assistance she requires.

Case managers in the telephonic program call the at-risk members, identify themselves as maternity nurses from the health plan, and conduct an extensive assessment to identify the women's medical issues and psychosocial needs. Based on the information they gather, they call back at least every 30 days, more often if necessary. If a woman develops gestational diabetes or hypertension, the case manager counsels her about diet, exercise, and following the medication regimen prescribed by her physician.

They follow up for 10 weeks after delivery, conduct a depression screening, discuss contraception and how to care for the baby, and reinforce the importance of a post-partum visit. They refer women with chronic illnesses to the regular case management program.

The health plan sends members a maternity tool kit with educational materials about having a healthy pregnancy, what to expect week-by-week, signs and symptoms that indicate problems, and information on the importance of regular physician visits. They reinforce the information during the phone calls.

"We try to identify pregnant women as early as possible in the pregnancy in order to have the greatest impact on the pregnancy. Our goal is to help our members have a healthy pregnancy and avoid having premature and low birth weight babies," Williams says. ■

High-risk women receive prenatal support

Collaboration is key to preventing preemies

Select Health of South Carolina is collaborating with community partners to ensure that pregnant women in their First Choice health plan's Medicaid population have full-term, healthy babies.

"The Medicaid population has a lot of health disparities based on social and economic factors, and many of them have barriers to receiving care. Our Bright Start program is

EXECUTIVE SUMMARY

Select Health of South Carolina collaborates with physicians and community agencies to make sure at-risk pregnant women get the medical care and social support they need.

- At-risk members are identified through claims data and information supplied by physician offices. Case managers enlist the aid of physicians and pharmacies in contacting the women.
- Case managers are assigned geographically and are familiar with community resources in the area.
- Members at highest risk receive in-home visits from a case management firm with which the health plan contracts.

open to all pregnant members and provides additional support for those at highest risk of a premature birth," says **Angela Glyder**, RN, CCM, director of integrated case management for the Charleston-based health plan.

Case managers help at-risk pregnant women develop care plans that will work for them, share information with the patients' prenatal care providers and collaborate with community agencies to make sure the women get the psychosocial support they need.

When members are identified as being pregnant, the health plan reviews historical claims and pharmacy data to determine if they have already had problems with a pregnancy or are taking medication for conditions like hypertension and diabetes that can affect a pregnancy.

Since the usual point of entry to the Bright Start program is the physician's office, the plan asks providers to fill out a risk assessment to help identify women at risk for premature deliveries. Using claims data and information from the physicians, the health plan stratifies women into low-risk and high-risk categories.

Members who are identified as low risk receive a welcome letter with information on having a healthy pregnancy, how to access care, when in their pregnancy they need to see their provider, and offering assistance in making appointments and helping the women access transportation to physician visits. The health plan sends all pregnant members a magnet with a phone number they can use to reach the program and be connected with a nurse.

High-risk members are assigned to a nurse case manager with experience in prenatal care who follows them throughout the pregnancy. Since the health plan covers the entire state of South Carolina, case managers are assigned to particular geographical regions. "They get to know the providers and the staff in their offices and are familiar with resources in the area so if members need help with clothes, electricity, housing, food, and other needs, they can connect them to community resources," she says.

One of the biggest barriers is getting in touch with the members, Glyder says. The case manager works with pharmacies and providers for assistance in getting phone numbers. If that doesn't work, she sends the member a letter describing the program and asking her to call. If pregnant members are hospitalized, the nurse contacts them while they're in the hospital and gets their phone numbers.

The case managers call the member, explain the program, and complete an in-depth physical and behavioral health assessment. "We know if there are behavioral issues or substance abuse, it can be a barrier to receiving early and consistent prenatal care," she says.

When the case manager finishes the assessment, she develops a care plan and shares it with the member's provider. The case managers call members after their physician appointments and help them understand what the doctor told them and make sure the members understand their treatment plan and any medication they are supposed to take. They clarify with the provider if there are any questions.

They call the women at intervals throughout the program, educate them about what they should be doing to have a healthy pregnancy, and about any signs and symptoms that indicate they need to see their provider. "Over time, the case managers build a close relationship with the members. Many members find the telephonic outreach less threatening than face-to-face contact and share information with the case managers they may never reveal in person," Glyder says.

Recognizing that the majority of young women today are tech-savvy, the health plan offers pregnant women the opportunity to sign up with text4baby, a national program that sends them text messages three times a week with the content geared to their stage of pregnancy. After delivery, the organization sends out regular text messages on caring for infants for a year.

"We think outside the box when it comes to engaging members. Young women are more apt to look at a text message than to listen to a voice mail. This offers a great way to stay in touch with them and keep them informed during their pregnancy," Glyder says.

The health plan has a contract with a vendor to provide face-to-face case management for members who have intensive case management needs. The vendor's nurses visit the members in their homes, providing education, support, and injections of 17 alpha-hydroxy progesterone (17P), a hormone that keeps the uterus from contracting during pregnancy.

Case managers with experience in the neonatal intensive care unit (NICU) work with parents of premature babies as they transition home from the hospital and follow the infants through the first year of life. "The nurses are

experienced in care for preemies and understand the issues these babies have and can guide parents as they care for the infants themselves," Glyder says. The case managers guide the parents through feeding, monitoring the baby, and help them navigate the healthcare system to ensure that the babies get the care and follow-up they need.

"Our main goal is to empower our members to advocate for healthcare for themselves and their children and to help them take control of their health and their healthcare decisions," she says. ■

Plan offers 3 steps to healthy pregnancy

Program provides CM for at-risk members

Passport Health Plan's Mommy Steps program helps at-risk pregnant Medicaid recipients get the care and psychosocial help they need to overcome the obstacles to a healthy pregnancy.

The Louisville, KY health plan's performance consistently exceeds the state of Kentucky's goals for managing the care of at-risk pregnant women.

"The Medicaid population faces a lot of challenges in receiving timely prenatal care and keeping appointments. We want to identify pregnant women as early as possible and ensure that they have regular visits with an obstetrician or a family practitioner who does obstetrics," says **Sherry Rumbaugh**, RN, BSN, director of care coordination and quality.

The Mommy Steps Program focuses on three steps to a healthy pregnancy: regular doctor visits, healthy eating, and making good choices.

The health plan provided initial funding through a grant and has partnered with the University of Louisville Hospital's Center for Women and Infants to promote its Kangaroo Care initiative, a program to increase breastfeeding among women on Medicaid. The Kangaroo Care program has received Outcomes Improvements grants from Passport to share the program with other hospitals in Kentucky. Today, 92% of birthing hospitals in Kentucky use the Kangaroo Care method, according to **Denise Barbier**, OTR/L, MOT, CLC, director of the program.

Kangaroo Care calls for skin-to-skin contact between the mother and infant in the delivery room to encourage the baby to breastfeed and bond with the mother. *(For more information on Kangaroo Care, visit www.kangaroomothercare.com.)*

To zero-in on at-risk members, the health plan analyzed adverse pregnancy outcomes for one year to determine what could have caused premature birth, low birth weight, or very low birth weight. "We had always stratified members into low-risk and high-risk categories but we decided to take a closer look. We examined information in the claims system and our obstetrical database and revised our list of high-risk conditions," Rumbaugh says.

Conditions that stratify women into the high-risk category include preterm labor or delivery with any pregnancy, premature rupture of membranes with any pregnancy, an incompetent cervix in any pregnancy, multifetal pregnancy with current pregnancy, pregnancy-induced hypertension with any pregnancy, chronic hypertension with any pregnancy, substance abuse with current pregnancy, and teenage pregnancy.

Beginning in 2012, the health plan asks providers to fax the American College of Obstetrics and Gynecology standard form for obstetrical care or a similar form to the health plan after the initial obstetrical visit. "This form gives us patient history and current risk factors and enables us to get a good idea of the patient's condition," she says.

The health plan sends low-risk members a

EXECUTIVE SUMMARY

Passport Health Plan's Mommy Steps program consistently exceeds the goals of the state of Kentucky for managing the care of at-risk pregnant women.

- Health plan reviewed preterm births to come up with a list of risk factors.
- Low-risk women receive mailings and phone calls from case management technicians at 22 to 24 weeks and after the baby is born.
- High-risk women receive regular interventions from case managers who educate them, help with their psycho-social needs, and accompany them to doctor visits when needed.

welcome letter asking them to call to update their information along with a Mommy Steps book, written by health plan staff, that educates them on what to expect during pregnancy and postpartum and during the baby's first few months.

The health plan's case management technicians call low-risk members between 22 and 24 weeks to educate them on signs that indicate when they should call their doctor. "Back pressure, bleeding, and leaky amniotic fluid are all warning signs that members may not recognize until it's too late and they're in labor," she says.

The case management technicians are not licensed clinicians but they have been trained to educate the members. If the member is having problems, the call is transferred to a nurse.

The technicians call the low-risk members again two weeks after the baby is born to screen for postpartum depression and remind the member to enroll the baby in the health plan. They call four weeks after delivery to make sure the member has a follow-up appointment and find out if she needs help with transportation.

High-risk members receive interventions from the case management technicians as well as calls from nurse care coordinators with experience in obstetrics and/or postpartum care. Early in the pregnancy, the care coordinators contact the women at one-month intervals, or more often if needed, and increase the frequency as the pregnancy progresses. They follow them for eight weeks after delivery.

If women have complex conditions or don't understand their instructions or their medication regimen, the care coordinator may accompany them to their doctor visit and assist the provider in helping the member understand.

The case managers work to build trust with the members, and most eventually participate in the program. "They see that we can help them with resources like cribs and housing assistance and that makes us non-threatening," says **Julie Wildt**, RN, BSN, CCM, manager of care coordination.

All of the case managers throughout Passport keep binders of community resources and share the information with each other.

"Regardless of the program they're in, our care coordinators all run into the same barriers, and they're great about sharing resources," Wildt says.

"Women on Medicaid are struggling to keep a roof over their heads, to be safe, to have food to eat every day, and resources to get to the grocery store, the drug store, and the doctor's office. With all of these challenges, it's hard for them to focus on their pregnancy," Rumbaugh says.

Passport Health tailors its prenatal programs to meet the needs of the Louisville area's growing immigrant population. Because there's a large Hispanic population in the area, the health plan has translated its educational materials into Spanish and employs a Spanish-speaking case management technician.

When the Louisville area had a huge influx of pregnant Somali women, the health plan rewrote its "Mommy and Me" book in the Somali-Bantu language and held weekly meetings for the Somali women at a community organization to educate them on the American healthcare system and answer questions. One of the nurse care coordinators attended the meeting and was assisted by a translator.

"It's hard to be in a country when nobody speaks your language and you're pregnant. We learned a lot about the Somali culture and all of the women delivered with no major complications," Rumbaugh says.

To address the challenges facing families with premature infants, the health plan has embedded two nurses with neonatal intensive care unit (NICU) experience in the NICU of a local hospital to educate mothers on caring for the tiny infants. The nurses perform both utilization management and case management, Rumbaugh says. "They are in the hospital, monitoring the baby's progress every day, reviewing the records, and working with the family as they progress toward discharge," she says. The nurses make sure the families have everything they need for a safe discharge, including a place to live, supplies such as a crib, and durable medical equipment they will need to monitor and care for the baby at home. They follow the women and babies after discharge and make sure they get to their appointments and learn to navigate the healthcare system.

"It's not unusual for a premature baby to go home with four or more appointments with providers. It's a challenge for any family, but

it's overwhelming to women who already have so many social issues," she says. ■

Study: Hospitals struggle to eliminate ED boarding

Leadership needed to beat back resistance

Emergency department administrators are well aware that crowding in the ED is associated with poorer patient outcomes, longer hospital stays, and decreased patient satisfaction. Yet a new study, published in *Health Affairs*, makes the case that even in the face of steadily increasing demand for emergency care, EDs are failing to take advantage of proven strategies to ease crowding.[1]

Every ED has its own unique challenges, but **Elaine Rabin**, MD, the lead author of the study and an assistant professor in the Department of Emergency Medicine at Mount Sinai Hospital in New York, suggests that one of the primary reasons for this failure is that patient boarding in the ED, one of the main drivers of crowding, is actually a hospital-level problem.

Patient boarding is the practice of holding admitted patients in the ED for long stretches of time, purportedly because inpatient beds are not yet available. Virtually no one approves of the practice, but boarding is nonetheless widespread, even though it adversely impacts an ED's capacity to care for new patients.

"The only way for boarding to be eliminated is for inpatient beds to open up more quickly for ED patients," explains Rabin. But actually getting the staff on inpatient floors to turn over the beds more quickly requires interdepartmental coordination, she adds. "It has been pretty clear from the people who have actually solved this problem that unless the leadership of the hospital is behind this, it doesn't happen."

Further, some hospital administrators appear to be more incentivized to address ED boarding than others, depending on the payer mix a hospital is accustomed to dealing with. "There are some hospitals where the majority of reimbursement comes from admissions through the ED, and there are hospitals where that is not true, so this will vary ... but there is a good amount of anecdotal evidence that hospital leadership is, in some cases, actively saving beds for better reimbursed patients."

Smooth schedule for elective procedures

What can hospitals do to reduce crowding? The *Health Affairs* study highlights several strategies that the authors suggest can remove admitted patients from ED hallways and facilitate throughput. For example, at many hospitals, scheduled catheterizations and elective surgeries are heavily booked in the early part of the week. The authors note that taking steps to smooth out this schedule so that procedures are evenly booked throughout the week can go a long way toward eliminating patient surges and the accompanying bottlenecks that can lead to boarding.

The strategy sounds like an easy fix, but Rabin suggests that hospital administrators often run into obstacles when trying to even out the schedule in this way. "There tends to be a lot of resistance up front, and certainly hospital administrators don't want to alienate surgeons who bring in a lot of money by trying to force them to operate on days when they don't want to operate," she says.

However, Rabin suggests that hospital leaders at Boston City Hospital, for example, have had success working closely with their surgeons to gradually smooth out the schedule so that elective procedures are not so front-loaded in the early days of the week. "It took a lot of gentle massaging of politics, but once it happened, the surgeons actually liked it better because without over-booking, the operating rooms actually ran on time and their schedules were more predictable," she says.

Move boarded patients to inpatient halls

Another strategy highlighted in the study involves moving patients boarded in the ED up to inpatient floor hallways where they can wait for a bed to be opened. "Peter Viccellio, MD, [clinical director of the Department of Emergency Medicine at Stony Brook University Hospital in Stony Brook, NY] is a big advocate of this, and he has demonstrated that it is safe," observes Rabin.[2] "It would be hard to argue that being on a quiet hallway on an inpatient floor is going to be worse for patients than being in a loud environment in the ED where the nurses might have 10 other patients and the doctors have their attention spread thin as well."

Advocates of this approach, such as **Stephen Pitts**, MD, MPH, an associate professor in the Department of Emergency Medicine at Emory University in Atlanta, say the approach should be

a slam dunk. "The ED is the worst place [for these patients] because that is where you need the new beds to turn around, and yet that is where patients end up because that is the tradition. This is an underused strategy," says Pitts. "The concept of taking patients who are in [the ED] hallways and putting them in the hallways in front of a bed they are about to occupy, makes perfect sense from the standpoint of safety and quality and, in fact, when a patient does get up onto an inpatient floor, their bed is often cleaned and ready to go more quickly."

However, Pitts points out that the strategy often becomes difficult to implement because of resistance from inpatient staff. "This is an added burden for them with no benefit," he says. "It would be much easier for them if the patient stayed in the ED until the inpatient bed was ready." In light of this resistance, Rabin suggests this is another clear instance in which hospital-level leadership is required for successful implementation.

Put a bed czar in charge of patient flow

A third anti-crowding strategy that an increasing number of hospitals are gravitating toward is the creation of a new position, often referred to as a bed czar, to oversee bed utilization and take charge when bottlenecks occur. "Everyone who works in the ED knows that when there isn't someone looking at the big picture, things get lost," says Rabin, noting that you can have one patient waiting for a bed on an orthopedic service for a day and a half while there are 10 beds available on the renal service. "Having someone oversee all of that makes a big difference."

Pitts agrees, explaining that it is a full-time job to make sure patients are moving through the system efficiently. "It used to be common for us to have horrible congestion in the ED with no space to see new patients, and I would go upstairs to see all of these supposedly uncleaned beds … and I would see one bed after another open for business, so there was this huge disconnect over what was being told and what was actually happening up there," he says. "These bed czars are the people who can actually match supply and demand and ease some of the congestion in the ED."

The most effective bed czars tend to be people with clinical as well as administrative skills, says Rabin, because it is important to have an understanding of which patients can safely go to what services. "Their territory is the whole hospital," she says.

"The underlying concept behind the bed czar, and really all of these solutions, is that the ED operates 24/7, but the rest of the hospital traditionally has not, so that can cause a lot of inefficiencies where patients might stay half a day longer than they need to just because they are waiting for a certain specialist who doesn't come in until 3 o'clock in the afternoon," explains Rabin. "Having a bed czar and having services available more hours in the day can make throughput more efficient."

Consider impact of practice intensity

While the link between boarding and crowding in the ED is crystal clear, less well-understood is the impact that practice intensity has had on ED crowding in recent years. To look at this issue, Pitts and colleagues analyzed patient data for ED visits between 2001 and 2008. They found that visits to the ED increased 60% faster than population growth during this period, and that crowding grew even more rapidly, mostly because of diagnostic tests and treatment intensity.[3]

In fact, Pitts suggests that the front loading of blood work, X-rays, and other tests ordered during triage may well be bogging down patient flow rather than speeding things along, as the practice was intended to do. However, he adds that some of this intensity has been driven by research findings and technological innovations.

"If you were to come in with chest pain in 2000, the chances of having a CT scan of the chest were much lower then they are now just because CT scan of the chest is now viewed as a good test for pulmonary embolism, but it wasn't back in 2000," explains Pitts. Similarly, ultrasound, which used to be rarely used in the ED, is now used routinely in some cases, he says. "People get more stuff done to them these days, but they are also discharged from the ED much more frequently than they used to be, so it saves inpatient resources in a sense. However, this front loads the ED with all the work that used to be done in the hospital."

While changes in the practice of medicine have driven much of this intensity, Pitts observes that it is also important to consider that the population of ED patients has also rapidly become older and sicker. During the study period, researchers found that Medicare patients aged 45 to 64 grew faster than all other age groups, and this group includes

patients who tend to be poor, disabled, and cognitively challenged, says Pitts.

"In 2009, 38% of the Medicare patients under the age of 65 were also Medicaid recipients, but even patients who are not dual-eligible are sicker in general, and they are less able to manage their affairs," explains Pitts. "The character of patients [who come to the ED] has changed, so the input part of the equation has changed. The output — the ability to admit patients upstairs — has changed, but the throughput has also changed because we are doing more stuff to the same people who have arrived."

Pitts acknowledges that at least some of this increased practice intensity has improved care, but there have also clearly been consequences on patient flow. "I started practicing in 1980, and I used to see 30 patients in a shift not uncommonly because we discharged people without further ado," he says. "I am lucky to see 15 patients in a shift now because of the complexity of the workup."

Satisfaction surveys push intensity of care

Pitts observes that there are two other "forces" that have driven up practice intensity and adversely impacted patient throughput. First, he points to Medicare's adoption of Evaluation and Management Coding (E/M) — the method of billing for services that was adopted in the late 1990s. "This really put a massive break on turnaround times and the ability to see a lot of patients, because in order to collect money, you had to do lots of stuff," explains Pitts.

The approach, which has become common practice among all payers, has led to over-documentation for relatively minor complaints, says Pitts, but he also stresses that E/M coding enables clinicians to collect more money from the same patients because more services are documented.

Also, while perception of legal risk is undoubtedly responsible for some overtreatment, Pitts suggests that a more important driver of utilization is the increasing practice of grading ED physicians on patient satisfaction surveys. "Patients are far more satisfied if you do a lot of stuff than if you don't; there is no doubt whatsoever about that," says Pitts. "It is clear that people think they get better care when they get more care."

While a massive expansion of primary care access could take some of the pressure off of EDs, Pitts suggests it is unlikely that the trend toward providing more care in the ED is going to reverse any time soon. "Skimping on care is nobody's favorite strategy; it is going to be very hard to do that."

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OIG work plan a useful guide for quality

Readmissions a continued focus

It must seem as though the number of important things to read and digest that come across a quality manager's desk is never-ending. But the 2013 Office of Inspector General (OIG) Work Plan should be at the top of your to-do list. It gives you a clear view of the things that are a concern for the OIG and with which you should ensure you are in compliance, says **Mike McGinnis**, a director and senior consultant with Warbird Consulting Partners in Shaver Lake, CA.

Of the 25 or so investigations related to hospitals that are listed in the plan, about half are new, he says. It is on those new items that you should focus your attention, McGinnis says.

Among those that are new is bundling. The OIG will look at whether bundling outpatient services delivered within two weeks of admission

into a single DRG might result in some savings, McGinnis says. The current rule is for three days prior to hospital admission.

The OIG is also interested in looking at payments for cancelled surgeries. "They want to make sure that a subsequent real surgery takes place after the cancelled one."

If you are working with a quality improvement organization (QIO), this is of interest to the OIG, which wants to assess barriers those QIOs experience when working with hospitals.

Rules around mechanical ventilators, which require a minimum of 96 hours for a patient to trigger payment, is also on the agenda, he says. This might be a particular concern for quality staff since getting patients off ventilators as quickly as possible is important to patient safety.

For those working in long-term acute care hospitals, interrupted stays are something the OIG has its eye on, and if you have a home health agency in your hospital, McGinnis says you should be particularly aware of the OIG's interest in the face-to-face rule that requires physicians who certify that a Medicare beneficiary is eligible for home health actually see the patient in person. "Make sure that your agency understands the rules, follows them, and documents that they are followed," he advises.

McGinnis suggests that utilization review, the chief financial officer, and quality improvement departments take a look at the work plan separately and together. "The OIG does us a favor by publishing this. It tells us outright what the areas of concern are. You can look at your history, at your data, and see if you are compliant in these areas. If you are not, set up systems to ensure you become compliant or create projects that will lead to it," he says. "This should be your blueprint."

At Sierra View District Hospital in Porterville, CA, **Donna Hefner**, RN, MS, CPHRM, the executive director of risk, has already been through the work plan. She calls it a great reference.

"For me it's a great communication tool," Hefner says. "It helps me convey what is important to the appropriate people on the compliance committee to share with their respective staffs."

For any item that is marked as new, Hefner says she and her team will do an audit to see if the hospital is compliant. Already looking at the payments for cancelled surgeries issue, they are pulling charts and having representatives from all disciplines look at the information to see whether they need to make changes, corrections, or implement a quality improvement project. They will continue to focus on any emergent issue until compliance is 100% or there are three consecutive quarters at the required benchmark.

"I've found it to be one of the most useful reports over the years," Hefner says.

A complete copy of the work plan is available at https://oig.hhs.gov/reports-and-publications/archives/workplan/2013/Work-Plan-2013.pdf.

SOURCES

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COMING IN FUTURE MONTHS

- How your peers are preventing readmissions
- Why cultural competency is important
- Keeping seniors healthy at home
- How to deal with difficult people

CNE QUESTIONS

1. Preterm babies are at risk for cerebral palsy, mental retardation, vision problems, and hearing loss.
   A.True
   B.False

2. How long after delivery do case managers from BlueCross BlueShield of Tennessee continue to follow at-risk pregnant women?
   A. 10 weeks.
   B. 8 weeks.
   C. 6 weeks.
   D. one month.

3. One way Select Health of South Carolina educates pregnant women about staying healthy is to offer them the opportunity to sign up for text4baby, a national program that sends them three texts a week for how long?
   A. The duration of the pregnancy.
   B. Until the child is a year old.
   C. Until six weeks postpartum.
   D. Until the woman is 37 weeks pregnant.

4. At what point in the pregnancy do case management technicians at Passport Health Plan call members to educate them on signs of premature labor?
   A. 10 weeks.
   B. 37-38 weeks.
   C. 22-24 weeks.
   D. As soon as the health plan knows they are pregnant.

CNE OBJECTIVES

After reading this issue, continuing education participants will be able to:
1. Identify clinical, legal, legislative, regulatory, financial, and social issues relevant to case management.
2. Explain how the clinical, legal, legislative, regulatory, financial, and social issues relevant to case management affect case managers and clients.
3. Describe practical ways to solve problems that case managers encounter in their daily case management activities.

CNE INSTRUCTIONS

Nurses participate in this continuing education program and earn credit for this activity by following these instructions.
1. Read and study the activity, using the provided references for further research.
2. Log on to www.cmecity.com to take a post-test; tests can be taken after each issue or collectively at the end of the semester. First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■

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Covering Case Management Across The Entire Care Continuum

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